Lisa Basile LMHP

*7561 Main Street * Suite 425 * Ralston, NE. 68127*
phone: 402.558.8224

Registration Information

PERSONAL INFORMATION:
(Complete on behalf of the Patient/Client)

Name: _____ DOB: _____ Sex: Male Female

Street Address: _____ City/State/Zip: _____

Home phone: _____ Cell: _____ Work: _____ SS#: _____

Preferred contact #: _____ **Emergency Contact (Name & Phone):** _____

Email address: _____

Marital status (circle): single married divorced widow

How did you hear about us? _____

PERSON(s) RESPONSIBLE FOR THIS ACCOUNT:

We cannot bill a 'third-party' without their signature on file

Name: _____ DOB: _____ Phone: _____

Address: _____ SS#: _____

FAMILY MEMBERS/SIBLINGS:

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

INSURANCE: **Are you using an EAP? Yes No** **Do you wish this office to file claims? Yes No**

Primary Insurance (Name & Address): _____

Name of Subscriber: _____ DOB: _____

ID#: _____ Group#: _____ Employer: _____

Secondary Insurance (Name & address): _____

Name of Subscriber: _____ DOB: _____

ID#: _____ Group#: _____ Employer: _____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize **Lisa Basile, LMHP** to release information necessary to process insurance claims relating to my treatment.
I authorize my insurance company to pay directly to **Lisa Basile, LMHP** all benefits otherwise payable to me.
I will be responsible for all expenses related to treatment not paid under this plan(s).

Client signature: _____ Date: _____

Guardian (if a minor): _____ Witness: _____